

AUTHORIZATION FOR SOCIAL SERVICES CHILD CARE

EES Program Administrator /Designee: _____	<input type="checkbox"/>	Approved
Signature: _____	<input type="checkbox"/>	Not Approved
Date: _____		

I certify the need for Social Service Child Care.			
Name (print): _____		Date: _____	
Signature _____		Title: _____	
Check:	<input type="checkbox"/> DCF Social Worker	<input type="checkbox"/> Physician	<input type="checkbox"/> Psychologist
	<input type="checkbox"/> Other Social Worker	<input type="checkbox"/> Family Preservation Specialist	
	<input type="checkbox"/> Other - Specify: _____		

Parent(s) Name: _____	KsCares Case Number: _____
Child's/Children: Full Name: _____	
Dates of Birth: _____	Social Security Number(s): _____
Child's/Children: Full Name: _____	
Dates of Birth: _____	Social Security Number(s): _____
Child's/Children: Full Name: _____	
Dates of Birth: _____	Social Security Number(s): _____
Child Care Provider: _____	Provider Type: _____
Address: _____	Telephone: _____

DCF USE ONLY	
Reason for Request	
<input type="checkbox"/>	Parent (inpatient) hospitalization.
<input type="checkbox"/>	Parent (outpatient) treatment.
<input type="checkbox"/>	Family in the process of DCF Intake Assessment.
<input type="checkbox"/>	Family receiving services through preservation contractor services or PPS Social Worker.
<input type="checkbox"/>	Documentation of parent/caretaker's need for child care is on file in case.